FAMIS
Covering Children With Affordable Health Insurance

Health Insurance for Children and Pregnant Women

This application is for Virginia's health insurance programs for children and pregnant women.
FAMIS and FAMIS Plus cover children. FAMIS MOMS and Medicaid cover pregnant women.

FAMIS MOMS
Covering Pregnant Women With Affordable Health Insurance

Application: ☐ New ☐ Renewal
Family ID # _____
Case Worker _____

Step 1

Tell us who is completing the application, where you live, and where you get your mail:

First Name	MI	Last Name	Phone Numbers	Preferred Language (See instructions)
			H ( ) W ( ) Other ( )	

Address	Apt. No.	City	State	ZIP	City/County of Residence
(Street)					
(Mailing)					

Step 2

Tell us if anyone applying for health insurance is pregnant:

Proof of pregnancy and due date are required. See instructions.

First Name	MI	Last Name	Expected Due Date
			(Month/Day/Year)

Step 3

Tell us about all the children and pregnant women under 21 living in your home:

If there are more than four children in the home, please complete steps 3 and 4 on another application (or on an Additional Child Form) and attach it to this application.

	Child 1	Child 2	Child 3	Child 4
Child's Full Name (First, MI, Last)				
Relationship to You				
Date of Birth & Sex	____/____/____ ☐M ☐F month day year	____/____/____ ☐M ☐F month day year	____/____/____ ☐M ☐F month day year	____/____/____ ☐M ☐F month day year
Child's Parent, Stepparent or Spouse Living in the Home (First, MI, Last)	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required
	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required
	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required	☐Mother ☐Father ☐Stepparent ☐Spouse Name: _____ (SS#) Not Required

Step 4

Tell us about the children under 19 and pregnant women under 21 applying for insurance:

	Child 1 *continued*	Child 2 *continued*	Child 3 *continued*	Child 4 *continued*
Child's Full Name (First, MI, Last)				
Applying for Health Insurance for Child?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

If you are applying for insurance for this child, answer the questions below. If you are not applying for this child, you may go to Step 5.

	Child 1	Child 2	Child 3	Child 4
Is Child a U.S. Citizen?	☐ YES ☐ NO If **Yes**, please provide City/County and State of Birth: ____ If **No**, please provide: Alien/INS # ____ Country of Birth: ____ Date Entered U.S.: ____	☐ YES ☐ NO If **Yes**, please provide City/County and State of Birth: ____ If **No**, please provide: Alien/INS # ____ Country of Birth: ____ Date Entered U.S.: ____	☐ YES ☐ NO If **Yes**, please provide City/County and State of Birth: ____ If **No**, please provide: Alien/INS # ____ Country of Birth: ____ Date Entered U.S.: ____	☐ YES ☐ NO If **Yes**, please provide City/County and State of Birth: ____ If **No**, please provide: Alien/INS # ____ Country of Birth: ____ Date Entered U.S.: ____
Child's SS# or date of application for SS#	(SS#)	(SS#)	(SS#)	(SS#)
Child Attends School?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Child's Race (See codes below)	Race Code # ____	Race Code # ____	Race Code # ____	Race Code # ____

RACE CODES: **1** White; **2** Black/African American; **3** American Indian/Alaskan Native; **4** Asian; **5** Spanish American/Hispanic; **6** Native Hawaiian or Other Pacific Islander; **7** Asian & White; **8** Black/African American & White; **9** Other or Unknown; or **A** Asian & Black/African American

	Child 1	Child 2	Child 3	Child 4
Child's Ethnicity	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO
Does Child Have Health Insurance Now? (See instructions for further explanation)	☐ YES ☐ NO If **Yes**, please provide: Type of Policy: ____ Company Name: ____ Policy ID # ____	☐ YES ☐ NO If **Yes**, please provide: Type of Policy: ____ Company Name: ____ Policy ID # ____	☐ YES ☐ NO If **Yes**, please provide: Type of Policy: ____ Company Name: ____ Policy ID # ____	☐ YES ☐ NO If **Yes**, please provide: Type of Policy: ____ Company Name: ____ Policy ID # ____
Has Child Had Health Insurance in the Past 4 Months? (See instructions for further explanation)	☐ YES ☐ NO If **Yes**, please provide: Type of Policy: ____ Company Name: ____ Policy ID # ____ Date Policy Ended: ____	☐ YES ☐ NO If **Yes**, please provide: Type of Policy: ____ Company Name: ____ Policy ID # ____ Date Policy Ended: ____	☐ YES ☐ NO If **Yes**, please provide: Type of Policy: ____ Company Name: ____ Policy ID # ____ Date Policy Ended: ____	☐ YES ☐ NO If **Yes**, please provide: Type of Policy: ____ Company Name: ____ Policy ID # ____ Date Policy Ended: ____
Why Did Insurance End in the Past 4 Months? (See reasons below)	Reason#____ Other ____	Reason#____ Other ____	Reason#____ Other ____	Reason#____ Other ____

REASONS CHILD'S HEALTH INSURANCE ENDED: (See Instructions) **1** Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. **2** Parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. **3** Insurance company discontinued coverage because child is uninsurable. **4** Cost of insurance exceeded 10% of monthly income (before taxes). **5** Insurance stopped/dropped by someone other than parent or stepparent living with child. **6** Stopped/dropped a COBRA policy. **7** Other.

Step 5

Tell us about pregnant women 21 and over applying for insurance:

If not applying for an adult pregnant woman, you may go to Step 6.

Full Name (First, MI, Last)		Applying for Health Insurance for a Pregnant Woman? ☐ YES ☐ NO
Her Date of Birth ____/____/____ (month day year)	Her Relationship to You:	Provide Full Name of Husband if Living in the Home:

Is the Pregnant Woman a US Citizen? ☐ YES ☐ NO	If **Yes**, please provide City/County and State of Birth: ________	If **No**, please provide: Alien/INS # ______ Country of Birth: ______ Date Entered U.S.: ______	SS#:	Race: (See codes below) Race Code#______	Ethnicity: Hispanic/Latino ☐ YES ☐ NO

RACE CODES: **1** White; **2** Black/African American; **3** American Indian/Alaskan Native; **4** Asian; **5** Spanish American/Hispanic; **6** Native Hawaiian or Other Pacific Islander; **7** Asian & White; **8** Black/African American & White; **9** Other or Unknown; or **A** Asian & Black/African American

Does Pregnant Woman Have Health Insurance Now? ☐ YES ☐ NO	If **Yes**, please provide:	Type of Policy ______ Company Name ______	Policy ID # ______

Step 6

Tell us about household income:

Complete the section below for each parent, stepparent, child, pregnant woman, and spouse living in the home and receiving income. List each source of income separately. Include income from jobs, self-employment, child support, Social Security benefits, unemployment compensation, and any other income received. List all income amounts before taxes and other deductions (gross income). Do not include income received by guardians, grandparents or other relatives. If there is no family income, write "**NONE**" in the chart below. (See instructions for explanation of all types of income that must be listed and the proof of income that must be provided.)

May we have your permission to get information from all employers, if necessary, about dates of employment and earnings? ☐ YES ☐ NO

Person Receiving Income	Employer's Name or Source of Income	How Often is Income Received?	How Much Gross Income is Received?
______ (First Name, MI, Last Name)	______ Employed by the state? ☐ YES ☐ NO	☐ Weekly ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Every Two Weeks	$
______ (First Name, MI, Last Name)	______ Employed by the state? ☐ YES ☐ NO	☐ Weekly ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Every Two Weeks	$
______ (First Name, MI, Last Name)	______ Employed by the state? ☐ YES ☐ NO	☐ Weekly ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Every Two Weeks	$
______ (First Name, MI, Last Name)	______ Employed by the state? ☐ YES ☐ NO	☐ Weekly ☐ Monthly ☐ Twice a Month ☐ Yearly ☐ Every Two Weeks	$

FAMIS *Select*: FAMIS offers help with private health insurance premiums through FAMIS *Select*.

If your child is approved for FAMIS you may choose to enroll your child in a private or employer health insurance plan instead of FAMIS. **FAMIS *Select*** may help you pay for it.

☐ If my child is approved for FAMIS, I would like more information about **FAMIS *Select***.

You are almost done. Turn the page over, complete the application, and remember to sign it.

Step 7

Tell us about childcare or adult daycare expenses:

Do you pay someone to provide childcare or adult daycare while you work? ☐ YES ☐ NO

	Person 1	Person 2	Person 3	Person 4
Full Name of person in daycare	_____ How much do you pay? _____ How often? _____	_____ How much do you pay? _____ How often? _____	_____ How much do you pay? _____ How often? _____	_____ How much do you pay? _____ How often? _____

Step 8

Tell us about medical bills in the last 3 months:

If a child is eligible for FAMIS Plus, a pregnant woman is eligible for Medicaid, or a newborn is eligible for FAMIS, you may be able to get help with medical/dental services in the last 3 months. Did any child or pregnant woman you are applying for receive medical/dental services in the last 3 months?

☐ YES ☐ NO

If **Yes**, list names of the children or the pregnant woman and the months in which they received medical/dental services.
(Note: Dental services are only covered for children.)

_____

_____

You must provide proof of household income for the months that the child or pregnant woman received medical/dental care. **DO NOT SEND MEDICAL/DENTAL BILLS.**

Step 9

Tell us if you have authorized someone else to follow up on this application:

If you would like to have someone else contact us for you, please complete the following:

I authorize (name) _____ and/or (organization name) _____

Address _____ City _____ State _____ Zip _____

Telephone _____

to receive eligibility and enrollment information relating to my child(ren) or the pregnant woman on this application. I also authorize FAMIS, the local Department of Social Services, and/or the Department of Medical Assistance Services to release information about this application to this person/organization.

Step 10

Signature: ***We cannot process this application unless it is signed.***

By signing below I certify that I have read my **Rights and Responsibilities** (located on the instructions page) and agree to all the conditions and terms. I also agree that all the information I have given on this application is true and correct to the best of my knowledge and belief. I understand that the information provided on this application can be used to establish identity for children under age 16. I also understand that if I give false information, withhold information, or fail to report required changes promptly or on purpose, health insurance coverage may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

_____ _____

SIGNATURE **(REQUIRED)** DATE

Application Instructions & Rights and Responsibilities

This Application May Be Used For: FAMIS or FAMIS Plus (children's Medicaid) for Children and FAMIS MOMS and Medicaid for Pregnant Women

How do I apply?
To get started, simply call our toll-free number **1-866-87FAMIS (1-866-873-2647)** or fill out this application and mail it to **FAMIS at PO Box 1820, Richmond, Virginia 23218-1820**, or fax it to **toll-free fax number 1-888-221-9402**. This application can also be mailed, dropped off, or faxed to the **local Department of Social Services** in the city or county in which you live. You may also apply online at **www.famis.org**.

For a child or a pregnant woman under 21:
Parents can apply for their children. An adult relative with whom the child lives may also sign an application on behalf of the child. An adult who has legal custody or guardianship may apply for a child but will need to attach a copy of court papers. A person authorized in writing, by a parent or legal guardian, to act on behalf of the parent may apply but must attach a signed authorization from the parent. Adults, married to a minor, may apply for their spouse. Children and pregnant women 18 and over or children emancipated by a court may apply for themselves.

For a pregnant woman over 21:
An adult pregnant woman may apply for herself. The adult husband of a pregnant woman, guardian, or an adult relative if the pregnant woman cannot sign for herself may apply on her behalf.

Step 1 **Information on person completing application:** Complete this section listing your name, address, city/county of residence and phone number. If we may call you at work, include that phone number. Please tell us the language you speak. Write the name of the language in the space provided, such as: English, Spanish, Vietnamese, Farsi, Korean, Kurdish, Arabic, Urdu, Russian, or any other language.

Step 2 **Information on pregnant applicant:** Complete this section if you are applying for insurance for someone who is pregnant. Write her name and expected due date. Attach proof of pregnancy from her health care provider to the application.

Step 3 **Information on all children and pregnant women under 21:** Provide information on all children and pregnant women under 21 who live in the home with you even if they are not applying for **FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid for pregnant women**. Although you can only apply for children under age 19 and pregnant women on this form, we need information on all children under 21 living in your home to correctly determine the size of the family. If there are more than 4 children under age 21 in the home, complete steps 3 and 4 on the Additional Child Form or on another application and attach it to this one. For each child under age 21 in the home please write the child's name, your child's relationship to you, the child's date of birth and check if the child is male or female. Write the name of the child's parents, stepparent, and spouse living in the home and check their relationship to the child. The Social Security Number (SS#) of the parent, stepparent and spouse is helpful, but not required information. If you are applying for a pregnant woman under age 21, include all of the same information.

Step 4 **Information about children under 19 and pregnant women under age 21 applying for insurance:**

Write the **name** of each person under 21 at the top of the same column again. Check whether you are **applying for health insurance** for each child or pregnant woman under 21. Answer all the questions in the column, if you are applying for health insurance for this person.

If the child or pregnant woman under age 21 is a **U.S. citizen** check yes. If they are **legal immigrants**, provide the child's Alien/INS #, country of birth and the date they entered the U.S. Some legal immigrants may qualify for these health insurance programs. You must provide a copy of the front and back of the child's/pregnant woman's Resident Alien Card or other proof of immigration status with this application. We do not need information on the immigration status of any adults in your family if they are not applying for health insurance. The INS (now known as USCIS) cannot use this application to deny you admission to the U.S., to harm your permanent resident status, or to deport you. If the child or pregnant woman is a U.S. citizen and qualifies for **FAMIS Plus** you will also be asked to provide proof of the child's or pregnant woman's citizenship and identity.

Tell us if the child is currently **attending school**.

Enter the correct code number for the person's **Race**. Codes are listed below the question on the application. Then check yes or no if they are of Hispanic/Latino ethnic origin.

Having other health insurance does not affect a child's eligibility for FAMIS Plus or a pregnant woman's eligibility for Medicaid but may affect eligibility for FAMIS and FAMIS MOMS. Tell us if the person has **health insurance now**, and what type of policy they have. (For example, comprehensive coverage, major medical, school-accident plan, dental coverage, etc.) Provide the name of the insurance company and the policy number.

Children are not eligible for FAMIS until they have been uninsured for 4 months unless they are pregnant. If the child had **health insurance during the past 4 months**, tell us about the policy. Please list the type of policy, name of insurance company, the policy number of the previous health insurance, and the date that it ended. There are some exceptions to this four month waiting period. Read the **reasons for ending health insurance** listed on the application and if any of them are true for this case, write the correct reason number in the space. If none of these reasons are correct, write a brief explanation of why the insurance ended. If the child's insurance was stopped because of the cost, (reason #4) you must provide proof of the monthly cost of the discontinued insurance. If the child's coverage was discontinued by an insurance company for a reason other than non-payment of premiums (reason #3), provide proof of this from the insurance company. If you want a further explanation about the exceptions to the four month waiting period, or more information on what to include with the application, call **1-866-87FAMIS** or go to **www.famis.org**. **This rule does not apply to FAMIS Plus**.

If you are applying for a pregnant woman, you do not need to provide information about health insurance in the last four months and may skip to the next step.

Step 5 **Pregnant Women 21 and over applying for Insurance:** Write the full **name** of the pregnant woman and check if applying for health insurance. Include her date of birth, her relationship to you (self, spouse, daughter, etc.), and her husband's full name, if he resides in the home.

If the pregnant woman is a **U.S. citizen** check yes. If the woman is a **legal immigrant**, provide the woman's Alien/INS #, country of birth and the date the woman entered the U.S. Some adults who are legal immigrants may qualify for these health insurance programs. **You must provide a copy of the front and back of the woman's Resident Alien Card or other proof of immigration status with this application**. If the pregnant woman is a U.S. citizen and qualifies for **Medicaid** you will also be asked to provide proof of her citizenship and identity.

A **Social Security Number** is required for all pregnant women applying for health insurance.

Enter the correct code number for the **Race and Ethnicity** of the pregnant woman. Codes are listed below the question on the application. Then check yes or no if the woman is of Hispanic/Latino ethnic origin.

Check if the woman currently has health insurance. If yes, indicate the type of policy, company name and policy identification number.

Step 6 **Household Income:** In some situations we may need to contact employers to get information about dates of employment and earnings. If you agree to let us do this in order to process this application, check yes.

For each parent, stepparent, pregnant woman, spouse, and child under 21 who lives in the home and receives income, list their **name and the source of income**. If the income is from a job, list the name of the employer. If the income is from another source (such as child support, unemployment compensation, Social Security, etc) write the type or source of the income. Check yes if the person works for a **State government**.

For each type of income listed, check how often it is received **(each week, every two weeks, twice a month, once a month, or yearly)** and write the gross amount of income received each time. **Be sure to write the amount of income before any taxes** or other deductions are taken (gross income).

You also need to provide **proof of each type of income** a family member receives. You will need to provide proof of all income received in the month before you apply. (For example, if you were applying in June, you would need to attach proof of all income received in the month of May. If you were applying in May you would need to provide proof of all income for April.)

To **provide proof of income from a job**, please attach a copy of all paycheck stubs for the month before you apply showing gross pay. If you do not have paycheck stubs, you can send a signed letter from an employer stating how much (gross pay) the employee was paid for each pay period for that month or you may call 1-866-87FAMIS to request a special form for reporting employment income. If you are self- employed, provide your most current tax return and all schedules or provide business records for last month.

You must also provide proof of other types of income received. Examples of **proof of other income** include:

- Child support — a print out from the Division of Child Support Enforcement Web site for last month, or copies of all child support checks received last month, a signed statement from the absent parent stating how much they pay each month, or a recent court order;
- Social Security (SSA or SSI) or Veteran's benefits — the current year award letter from the Social Security Administration or the VA;
- Unemployment compensation — a print out from the Employment Commission of all payments for the last month, benefits award letter, or a copy of all checks received last month.

If income is different from month to month, you may provide proof of the last 3 months of income to show an average income. If you have questions about what income to report or what proof is needed, please call **1-866-87FAMIS** or your **local Department of Social Services**

FAMIS *Select*: If your child(ren) are approved for FAMIS, you may choose to enroll them in a private or employer sponsored health insurance plan. FAMIS *Select* can help with the premiums. If you are interested in this program check the box and we will mail you additional information if your child is approved for FAMIS.

Step 7 **Childcare or Adult Daycare Expenses:** Certain child and adult daycare expenses may help a person qualify for FAMIS Plus or Medicaid for pregnant women. Tell us if you **pay for childcare or adult daycare while** you work. If the answer is yes, write the **name** of each person in daycare and how much you pay for their care and how often you pay it. (For example: $50 a week or $200 a month.) You can even report this expense if you are paying a relative to care for the children. The adult daycare expenses must be for an incapacitated spouse or parent of the person applying for health insurance.

Step 8 **Medical Bills in the Last 3 Months:** If a child qualifies for FAMIS Plus or a pregnant woman qualifies for Medicaid, you may be able to get help with **medical and dental bills for the past 3 months (dental bills are only covered for children)**. If your baby was born in the last three months, FAMIS may also be able to help with the newborn's medical bills. Tell us if a child or pregnant woman applying for insurance had any medical bills during the last 3 months. If the answer is yes, write the **name** of the child or pregnant woman who has medical bills and the **month** in which they received the medical or dental service. You will also have to show proof of family income for that month so we can determine if they would have qualified for FAMIS Plus, Medicaid, or FAMIS at the time the medical care was received. If a child older than three months qualifies for FAMIS or a pregnant woman qualifies for FAMIS MOMS, medical bills will only be covered from the first day of the month in which the signed application was received by FAMIS or at the local Department of Social Services.

DO NOT SEND MEDICAL OR DENTAL BILLS. We cannot pay for bills sent from individuals. If the child or pregnant woman qualifies for this retroactive coverage, we can pay for bills submitted by doctors, hospitals, dentists, pharmacies, or other medical providers for medical/dental services provided to the FAMIS Plus child, Medicaid pregnant woman, or FAMIS newborn during that time.

Step 9 **Release of Information:** If you would like someone else to be able to receive information about this application, **clearly print the person's name** or the name of an **organization, the address, and phone number** in this section. We will not release any information about this application to anyone except you or your spouse living in the home, unless you tell us who you want to be able to receive this information.

Step 10 **Signature:** Before you sign this application, make sure all the information is correct and read the section on your **Rights and Responsibilities** carefully. When you sign the application you are agreeing to all the statements under the Rights and Responsibilities. **Sign and date the application.** We cannot process an application without a signature.

Final checklist:

- ☐ Did you answer all the questions?
- ☐ Did you attach proof of all of last month's income?
- ☐ Did you attach any other necessary documents?
- ☐ Did you sign the application?

Mail to FAMIS at PO Box 1820, Richmond, VA 23218-1820 or fax to FAMIS at 1-888-221-9402 or drop it off at your local Department of Social Services today.

YOUR RIGHTS AND RESPONSIBILITIES

(Read this section before signing the application)

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs, or disability consistent with state and federal law. I can file a complaint if I feel I have been discriminated against.
- Request, in writing, a hearing or review of any negative action that affects eligibility for or receipt of FAMIS, FAMIS Plus (children's Medicaid), FAMIS MOMS, or Medicaid for pregnant women. This includes timely decisions made on this application. I understand that there will be no opportunity for review of a negative action if the sole reason is for lack of funding for FAMIS or FAMIS MOMS.
- Receive services from the Division of Child Support Enforcement (DCSE) and receive the booklet "Child Support and You". I further understand that failure to apply for such services will not affect my child(ren)'s eligibility for FAMIS or FAMIS Plus. I also understand that if an adult pregnant woman is found eligible for Medicaid, has children, and is separated or divorced from her husband, she may be required to cooperate with DCSE to receive benefits.

I further understand and agree that:

- This application could lead to enrollment in FAMIS or FAMIS Plus for the children or FAMIS MOMS or Medicaid if the person applying is pregnant. I understand that they will be enrolled in the appropriate program based on eligibility rules.
- The State and its contractors may contact other State and Federal agencies to verify any information that affects eligibility for coverage of the children or pregnant woman applied for on this application.
- The State and its contractors may exchange information on this application and medical, health, or other information relating to the child(ren)'s or pregnant woman's coverage with other agencies and contractors to assist with application, enrollment, administration, quality control, and quality assurance. This includes companies offering health insurance to the child(ren) or pregnant women.
- The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by the child(ren) or pregnant women.
- Each provider of medical services to the child(ren) or pregnant woman may release any medical or other information necessary for the provider to be paid.

As an enrollee in FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid, I understand:

- I may be responsible for paying a co-payment for some FAMIS medical services received by my child(ren);
- I may be responsible for paying co-payments for non-pregnancy related services for the pregnant woman enrolled in FAMIS MOMS or Medicaid;
- That FAMIS Plus cases for children and Medicaid for pregnant women cases, will be maintained by the local Department of Social Services where the person lives;
- That FAMIS and FAMIS MOMS cases will be maintained by the FAMIS Central Processing Unit (CPU);
- That for individuals enrolled in managed care, a premium is paid each month to the MCO for the person's coverage. If the child or pregnant woman is not eligible for FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid because I did not report truthful information or failed to report required changes in my family size or income, I may have to repay the monthly premiums paid to the MCO. I may have to repay these premiums even if no medical services were received during those months; and
- I must report any changes in the information provided on this application to the FAMIS at 1-866-873-2647 or my local Department of Social Services agency.

FAMIS and FAMIS Plus must be renewed at least **every 12 months**. It is very important that you report any change in your address to the agency that is managing the case. If we do not have a correct address, we will not be able to notify you when it is time to renew coverage and the child will be cancelled from the program.

Help us keep your children covered — tell us if you move!